Uniform Business Office Newsletter

Volume 1, Issue 3 November/December, 2002

OVERVIEW OF ARTICLES IN THIS ISSUE

The life so short, the craft so long to learn.
--Hippocrates

"Moving On"

LT COL LINNES CHESTER
DoD UBO Program Manager

As all of you know, 1 October 2002 welcomed the start of Outpatient Itemized Billing (OIB) for the Military Health System. It was a challenging initiative that came to fruition through the talents of many at all levels. With your support and that of your Service managers: MSgt Jeannine Kepner, Air Force, Mr. Doug Ashby, Army, and Mr. Michael Edwards, Navy, we were able to bring about an important business change.

While there remains work to be done to smooth some deployment bumps, I am confident that we are on the right track to improve our financial operations that will ultimately benefit our beneficiaries. With your continued support, I have no doubt we will be successful.

As we continue to improve on OIB, we have started to focus some attention on inpatient billing. A key part of this is the Industry-Based Workload Alignment (IBWA) that also started to a lesser degree on October 1. IBWA will assist in breaking out professional and institutional charges, which will help align us with civilian practices.

Information on IBWA and other inpatient-related areas will come from both the UBO and the Unified Biostatistical Utility (UBU).

Although it may seem so, outpatient and inpatient billing are not the singular interest of UBO. While billing is indeed important--generating in excess of $128 million in FY 01--there are related initiatives underway which we believe will benefit the many customers we serve. Let me share a few with you.

Naval Medical Center San Diego stepped forward a few months ago to take part in a pilot project with WebMD to expedite payment of pharmacy claims. Because of the MHS-wide potential, it is receiving oversight by Tricare Management Activity (TMA) UBO. Initial numbers appear promising. The pilot project was to conclude this month, but has been extended at least through December 2002. The additional time will help resolve some procedural issues with payers that will facilitate the billing process.

Naval Medical Center Portsmouth, Naval Hospital Norfolk and Navy Judge Advocate General are engaged with TMA and Troveris Medical Solutions in a medical affirmative claims (MAC) pilot test designed to expedite MAC payments. As with the pharmacy test, we believe there is much financial potential. Once we determine the most efficient process to access claims data, we will be able to proceed more swiftly.

There also has been some movement in trying to find ways to improve the billing services we provide to non-DoD civilians, particularly those overseas. Rather than have them file their own claims, the hope is that a system can be devised to assist. This has been a long-running issue (which has generated numerous Congressional inquires) that we hope to settle,

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COMMUNICATION - INFORMATION - CHANGE

Change affects everyone differently. Employees who are affected by or involved in change have different needs, agendas and understanding of what will happen in the change process.

The change to Outpatient Itemized Billing (OIB) will affect every corner of an MTF. Neither the change agent nor the facility leadership will be able to anticipate every effect or wrinkle in the process. Listening to the feedback of the people who have to carry out the work is important before the change is solidified. The issues that are raised are too often dismissed as examples of resistance, rather than issues to be addressed. People involved in a change often have important information about the change they do not share until they are brought into the process. The members of the Change Team often are not aware of certain aspects of the work processes they are changing and they, therefore, embark on their design with incomplete information.

To get OIB off to a good start, communication is vital. Make sure that all aspects of a change plan are communicated as soon as possible to everyone affected. The people who do the work probably also have ideas regarding change, and their input can be very valuable. The process of defining, contacting, and involving those employees involved in the change to OIB should begin at the very outset of the change process. The more time that elapses before employees are involved, the greater the chance of destructive rumors, lowered morale, and misperception about the change.

In a vacuum, people fill up the absence of information with their worst fears. Change agents should encourage the organization to provide relevant and perhaps surplus information and let people pick what they want.

The more time spent in building commitment and understanding up-front, the less time it takes to get people on board to change to OIB.

WATCH THE SPELLING

Proofread all e-mail sent on behalf of your organization. The image you protect may be your own. Here are eight of the most frequently misspelled words:

Accommodate
Embarrass
Occasion
Commitment
Separate
Develop
Supersede
Business

What's Holding You Up? Use the UCF!

Does your MTF fill prescriptions written by outside civilian physicians? If so, you know that the prescription often comes without the diagnosis code. This diagnosis code is a requirement for a bill to be generated on the UB-92 Claim Form. TPOCS will not let the bill be completed without a diagnosis code entered. In order to get the diagnosis code, the civilian provider must be contacted. This generates unnecessary extra work for the billers. The reason for the need for a diagnosis code is that the UB-92 Claim Form is considered a medical claim form and insurers look for a diagnosis code.

On the other hand, prescriptions can be billed on the Universal Claim Form (UCF) without a diagnosis code! The UCF is not considered a medical claim form but is specific to prescriptions. The UCF is the default claim form where all prescriptions are listed unless the billers deliberately change the claim form default per insurer on the insurance table maintenance screen.

CHANGE IS EVERYBODY'S BUSINESS!

Long range planning does not deal with future decisions, but with the future of present decisions.
--Peter Drucker

APPROVAL:
The opinions of others can be valuable information. Happiness depends on approval of self; that achieved, approval by others tends to follow.
--Unknown

Never grow a wishbone where your backbone ought to be.
--Unknown

A Guide to Hold Periods

Did you ever wonder what a hold period is and why it is an important part of OIB? Well, here's your chance to find out!

A hold period is basically a time frame when data is held.

For OIB, there are actually two hold periods; one in CHCS and one in TPOCS. These hold periods serve two different purposes.

CHCS Hold Period

The Third Party Collection Program is built on collecting and billing Other Health Insurance (OHI). Without OHI, no monies can be collected. Prior to OIB, OHI was entered into both TPOCS and CHCS. However, with OIB, OHI is now entered into CHCS, and an updated file is pushed to TPOCS every evening.

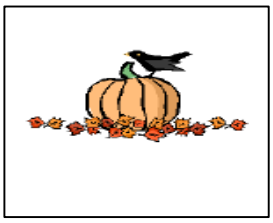
Sometimes, staff may get busy and cannot enter OHI into CHCS immediately. Thus, CHCS has a three-day hold period starting from the date of service. This means if the encounter is coded and completed in CHCS/ADM on the date of service, then that record is held for three days waiting to see if OHI is entered.

If OHI is not entered into CHCS during the three-day hold period, the clinical record does not get sent to TPOCS for billing. This does not mean that MTFs cannot bill for the encounter; it just means that the biller has to obtain all the necessary information and manually type the information into TPOCS. There is one caveat, however; OHI must first be entered in CHCS so that the patient's insurance information is sent to TPOCS.

What happens if the clinical information is not coded and completed in ADM on the same date as the visit? Let's say the record was completed a week after the date of encounter. Since it is past the three-day hold period, CHCS looks at the record immediately to see if that patient has OHI. If there is no OHI associated with that patient, then the clinical information is not sent to TPOCS. If there is OHI, the record is sent to TPOCS immediately.

TPOCS Hold Period

Once the clinical information is sent to TPOCS, the information stays in TPOCS for an additional seven days. This information does not show up on the Select Bills Screen until seven days have passed.



The TPOCS hold period serves several purposes:

The data is held in case there are any additional ancillary encounters to match up with the original clinic encounter.

For example, a physician may order a laboratory or radiology test, but the patient comes back later. If the person who enters the encounter checks the box that it is related to a previous encounter, it should match up to the original encounter and is billed on the same claim form rather than on two separate claim forms. Also, if the date of service is the same, the ancillary data will match up to the clinic encounter.

In case any updates to the clinical records are made and changes are made during the seven-day hold period, then the new record replaces the original record. If the changes are made after the seven-day hold period, then the record is still sent to TPOCS but does not update the original record. The billers should check the encounter to ensure that a previous record was not already billed.

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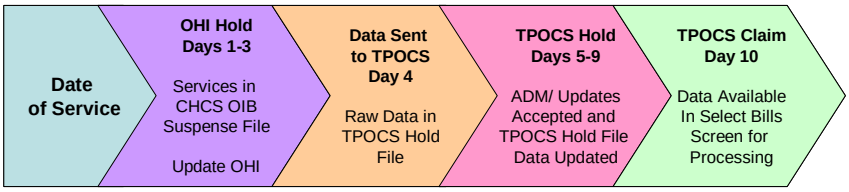
Cheers on all success!
--Gordon Hinckley

Change does not change tradition. It strengthens it. Change is a challenge and an opportunity; not a threat.
--Prince Phillip of England

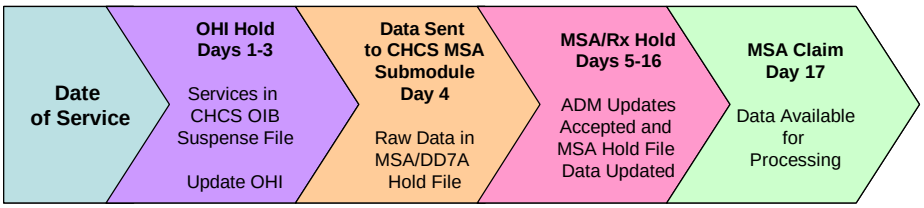
Everyone is trying to accomplish something big, not realizing that life is made up of little things.
--Frank A. Clark

Continued from Page 3
(Hold Periods)

Billing Cycle Timeline for TPC



Billing Cycle Timeline for MSA



OIB UBO REFERENCES AND WEB PORTALS

Reference Sources	***Web Portal***
Uniform Business Office (UBO)	http://www.tricare.osd.mil/ebc/rm_home/ubo_home.cfm
Uniform Biostatistical Utility (UBU)	http://www.tricare.osd.mil/org/pae/ubu/default.htm
MHS Helpdesk	http://www.MHS-helpdesk.com
Third Party Outpatient Collection System (TPOCS)	http://www.tpocshelpdesk.com
CHCS Implementation Alerts and OIB	http://fieldservices.saic.com
UBO Questions	ubo@tma.osd.mil

The truth is more important than the facts.
--Frank Lloyd Wright

The good news: Computers allow us to work 100% faster. The bad news: They generate 300% more work.
--Unknown

UBO FUTURE FEATURES

Collecting OHI Information

Inpatient Itemized Billing (IIB) 3rd Quarter '03

Continued from page 1 ("Moving On")

with input from you and your Service Managers, sooner rather than later. Because they are not DoD, it may be necessary to seek Congressional intervention. If this becomes the path we must take, then the earliest we could submit legislation is September 2003. However, this timetable could change based on Congressional and Assistant Secretary of Defense (Health Affairs) interest. In the meantime, any MTF efforts and recommendations to help those that support DoD are welcome.

We are beginning discover more about the need for MHS-wide change management (CM) in the business arena. With the large scale changes that loom on the horizon, the importance of CM cannot be overlooked. Health Affairs, TMA, Army, Navy and Air Force medical leadership is being routinely engaged in discussions on CM; they will be the decision-makers on whether or not we proceed.

Finally, the UBO conference scheduled for April 2003 in San Diego will expand to include UBU participation. Messages have gone out asking for lecture topics. The conference will no doubt be both educational and enjoyable; your input will make it so.

Thank you for allowing me to share some thoughts with you. I appreciate all of your hard work that is helping move the MHS forward. Your involvemen has been and will remain essentia Please do not hesitate to contact me on any topic. It is through your input tha keeps us moving in the right direction.

"Let's Make It Happen"

UBO Conference Spring 2003 San Diego, CA

Look for details in upcoming issues of the UBO Newsletter

Life is a series of collisions with the future; it is not a sum of what we have been, but what we yearn to be.
–Jose Ortega, Spanish Philosopher

GOT QUESTIONS?

Call the

OIB HOTLINE
1-866-STI-4UBO

PANEL MEMBERS NEEDED!

TRICARE CONFERENCE

27-30 January 2003

Washington, DC

Three panel members are needed to present at the Conference. Please contact your Service Manager for details.

Individual commitment to a group effort -- that is what makes a team work, a company work, a society work, a civilization work.
--Vince Lombardi

People who never get carried away should be.
--Malcolm Forbes

Change is inevitable - except from a vending machine.
--Robert C. Gallagher

THE BIG BANG THEORY

Outpatient Itemized Billing (OIB) became effective as planned on 1 October 2002. The "Big Bang" implementation of OIB was the result of years of hard work and planning. The combined efforts of TMA Uniform Business Office, Army, Navy, and Air Force as well as that of the Information Technology Program Offices made this significant milestone in DoD's history possible. From changing laws to writing business rules to enhancing systems to training personnel, DoD has had its hands full.

Is it all worth it? Many have asked this question, and the answer is a profound YES. The "Big Bang" is just one in many steps to align the Military Health System (MHS) with the ways of civilian medical facilities. During the last few years, DoD has received and continues to receive an increasing amount of payer denials and reductions in reimbursement due to the fact that we have not entered into the mainstream of medical billing standards.

Continuing down this road would eventually lead us to a dead end. Gone are the days that we can use the all-too-familiar phrases "Yes, but we are DoD" or "DoD doesn't work that way." No longer can DoD expect to be treated differently. The time has come for us to jump into the game with all the other players. The upcoming months will be a challenge for all.

Everyday new findings and obstacles are uncovered, but be encouraged that as these obstacles surface, they are being addressed as soon as possible. Officials at the TRICARE Management Activity (TMA) welcome suggestions as well as concerns. The desire to make this new program a success is a driving force.

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Your Role in Communication Improvement

Research indicates that managers spend somewhere between 50% - 80% of their total time communicating in one way or the other. This isn't surprising, since communication is so critical to everything that goes on in an organization. Without effective communication, there can be little or no performance management, innovation, understanding of clients, and coordination of effort. Furthermore, without effective communication, it is difficult to manage the expectations of those who are in a position to make decisions.

It can also be said that many managers do not communicate well, and do not set an organizational climate where communication within the

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Use of CPT Code 99499

There have been many questions lately about the use of CPT code 99499. The *Professional Services and Outpatient Coding Guidelines*, released on October 1, 2002, have provided guidance on the use of 99499 to document encounters. The UBU has issued this guidance as a workaround for the ADM requirement that every appointment requires an E/M code. In the coding world, there are some instances where an E/M code is not appropriate. For example, this could include Ambulatory Procedure Visits (APVs) and procedures that include an evaluation component.

This translates to billing by not producing a bill that includes an E/M code. The reason behind this is that 99499 is considered an "unlisted" code whereby there is no work relative value unit (RVU) and no rate associated with the code. Because there is no rate attached to the code, no bill will be produced.

This code will be listed on the TPOCS error report as there is no rate. If there are other codes included with the encounter, the bill will be produced without the 99499 code listed. If 99499 is the only code listed, then no bill will be produced at all.

Dealing with People During Change

Accept that it is natural to feel confused, frustrated and anxious.

Express your feelings; create a safe environment so others can express how they feel.

Let go of the past.

Involve people.

LISTEN!

Help your staff focus on the job at hand.

Establish and build trust.

Prepare people.

Clarify expectations.

Look for natural leaders to champion the change.

COMMUNICATE!

SIT: Making it Work

The new DoD Standard Insurance Table (SIT) brings many changes in how the MTFs manage their local claims address data. The DoD SIT creates a centralized managed claims address file for all UBOs worldwide. The TMA Verification Point of Contact (VPOC), Mr. Patrick Hamilton, collects sites' SIT input and compiles updates each quarter. **The quality of the SIT data greatly depends on the active participation of the users.**

Sites may submit requests to add, edit, or delete SIT entries. By submitting these requests, sites will replace local Temp entries with a permanent SIT entry with the next SIT quarterly update.

Once an entry is published on the SIT, all sites can use this standard entry. TMA is currently working on a new format for the SIT Add Request, which will include indicators for Add, Edit, and delete requests, and a field to indicate the SIT code to which the submitted request is related.

Coming together is the beginning. Keeping together is progress. Working together is success.

--Henry Ford, American Industrialist

Tips for Submitting SIT Requests

Collect your Temp entries. One way to do this is to run the CHCS Standard Insurance Company Report (Temporary Entries). From this list of Temp entries, you can complete the SIT Add Request format and e-mail it to: patrick.hamilton@tma.osd.mil.

Be careful what you information you submit. This has actually been a big problem with some sites submitting incorrect or duplicate entries. Patrick researches each request and provides feedback line by line, so please be sure that you are sending good data!

Make sure your requests have been verified. All requests should have a working telephone number, which the user has called (just before submitting their SIT request) to verify the claims address.

Use the Add Request Format. We like to help Patrick as much as possible by using (and not altering) the Add Request. This helps ensure SIT requests are processed faster and are more likely to be included in the next update.

Include your Temp Code. CHCS assigns Temp codes as temporary short names to new entries. Submit these Temp codes so that they can be automatically replaced with a standard code and format.

Call if you have questions. If you have questions on SIT data, please contact Patrick at: 703-933-8352 or patrick.hamilton@tma.osd.mil.

Questions on SIT and OHI concepts may also be directed to Grace McPherson at: 910-436-1042 or gmcpherson@nc.rr.com.

Note: The new SIT Add Request Format will be available soon on the UBO website and distributed to the Service UBO Managers for distribution.

Are You Concerned About Unethical Coding and Billing Practices?

The subject of medical ethics is more actively debated since the Balanced Budget Act (BBA) and the Health Insurance Portability and Accountability Act (HIPAA) were enacted. It is the coder's responsibility to inform superiors of unethical or possible illegal coding practices. It is illegal to report incorrect information to government funded programs such as Medicare, Medicaid, and CHAMPUS. It is also not acceptable to report incorrect information

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What Are Records And Why Are They Important?

Records are the various documents generated, received and filed by your office. Records can include correspondence, memos, reports, minutes, agendas, purchase orders, fliers, news clippings, and other pertinent documents.

Records serve three major purposes: 1) They chronicle recent activities of your office or department and thus assist department members with the day-to-day operation of the department or office; 2) They serve as a legal record; 3) They are historic records of the activities of your office or organization as a whole.

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to private insurance carriers.

Some examples of illegal or unethical coding are:

- Upcoding to increase payment when the case documentation does not warrant it.
- Coding procedures for payment which were not performed.
- Billing for services not provided.
- Altering fees on a claim form to obtain higher payment.
- Coding a service differently in order to have it covered.
- Billing for procedures over a period of days when all treatment occurred during one visit.
- Changing the date of service.
- Falsifying information on applications, medical records, billing statements, etc.
- Using a deceased provider's number in order to obtain payment.
- Using procedure codes that exceed the level of services actually provided.

Intentional deception or misrepresentation of data, which could result in some unauthorized benefit, is a felony. If detected, financial or prison penalties can be imposed.

Your role as an insurance billing specialist is to complete the insurance claim accurately and to facilitate reimbursement for your provider. It cannot be stressed strongly enough that the biller and coder will not escape liability by pleading ignorance. When an insurance billing specialist bills for a physician and completes the insurance claim form with false information, he/she may be found guilty of conspiring to commit fraud. It is not necessary to receive monetary profit from a fraudulent act to be judged guilty.

If an employee *knowingly* submits a fraudulent Medicare claim at the direction of the provider and the practice is subsequently audited, the provider *and the employee* can be brought into litigation by the State or Federal government.

- **Did You Know . . .**

  You cannot add procedure codes to an existing encounter in TPOCS?

BEST PRACTICE FEATURE

As the result of the deployment of OIB, the operational tempo at military hospitals and clinics has increased, setting in motion increased clinical expectations and responsibilities. In an effort to leverage the ability to identify, evaluate and generate best business practices throughout the MHS, this column will highlight some of the improvements championed at MTFs worldwide.

NH Camp Pendleton champions OIB!

The opportunity to first demonstrate and test OIB was conducted during Alpha Testing. Naval Hospital Camp Pendleton, the CHCS host site, and Naval Hospital Twentynine Palms were selected as test sites.

NH Camp Pendleton, under the direction of LT Christian Wallis, Department Head, Patient Administration,

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What is Change Management?

Change Management is a planned approach to supporting and integrating change, which positively impacts business results and increases an organization's capacity to deal with current and future change.*("Managing Transitions - Making the Most of Change", William Bridges, 1991)*

FILING TIPS

A simple, fundamental principle for eliminating desktop clutter is the Deal With It—File It—Pitch It-rule.

Do not file documents because you might need them some day. Only file documents you know you will need to refer to.

Do not save drafts of documents unless they show major changes in wording or thinking.

Do not save multiple copies of a document; one copy is enough.

Do not overstuff file folders. If you have too many documents for a folder, simply write "1 of 2" or "2 of 3" on the folders

Do not overstuff file drawers. This makes refiling difficult.

Weed files regularly.

Use markers to indicate when a file has been removed from the system for use.

Continued from Page 8 ("Best Practice")

championed the opportunity to improve billing and coding processes through the development of an Itemized Billing Team chartered by the Executive Steering Committee at the command. This multi-disciplinary team included providers, business office staff, coders, and other medical records personnel, and satellite clinic staff. They started with the identification of patients' OHI and ended with the command receiving payment for services. They also saw this as an opportunity to improve population health data through an increase in coding accuracy.

According to LT Wallis, the most important part of the process was planning for change. By visiting local civilian hospitals to examine their revenue cycle and business practices, NH Camp Pendleton identified areas for improvement of coding and billing at their facility.

Through the use of a **Plan Do Check Act** (PDCA) **Cycle** methodology, and Plans, Actions and Milestones for each department, they established the following goals, which will be benchmarked and measured:

- Obtain 100% patient information on Other Health Insurance.

- Obtain 95% accuracy in clinical coding.

- Obtain 80% reimbursement on filed claims.

During the first week of OIB deployment, the command conducted coding training for providers. The Director of Medical Services orchestrated this training initiative. The Family Practice clinic conducted the training. In addition, Tiger Teams were formed to focus on certain departments and other areas within the facility to meet goals.

If you would like additional information on Naval Hospital Camp Pendleton's Itemized Billing Team, please contact LT Christian Wallis at: ctwallis@cpen.med.navy.mil.

VOICE MAIL VS E-MAIL

Marjorie Brody, CEO of Brody Communications Ltd., suggests that if a message is longer than 30 seconds, it's probably better to send e-mail. Keep e-mails brief. Don't go beyond one screen and keep sentences short, between 10-25 words. An e-mail is more readable if it's shorter.

We'd like to take this opportunity to invite MTFs to submit their best practices for OIB improvement and implementation through their Service UBO Managers and to TMA UBO, so we can share your ideas in the newsletter and other appropriate forum. You may submit your best OIB business practice to: ubo@tma.osd.mil.

THANK YOU! *For Each and Every* FAQ

www.tricare.osd.mil

Click on **UBO**
Click on **DOCUMENT CENTER**
Click on **ITEMIZED BILLING**
Download **IB FAQs**

Letter-Writing Tips

You want to write a letter fast? Just follow this simple outline:
Be concise - Express clearly and briefly what action you would like. One or two paragraphs should be enough.
Request specific action. What do you want the reader to specifically do?
Put the situation in concrete terms. Use specific numbers, quotes, prices, etc. if you have them available.
Close on a positive note.

Are you in a rut? Then consider:

Break your routine. If you always do what you've always done, you're always going to get what you've always gotten. Try new things: listen to different music; read books or publications you wouldn't ordinarily read; drive to work a different way; talk to strangers; travel to a place you haven't been; take classes for fun; or order something different in a restaurant.

Ideas without action are worthless.
--Harvey Mackay

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("Communication")

organization is managed effectively. This isn't surprising, since a manager who communicates ineffectively and does not encourage organizational communication is unlikely to hear about it. Poor communication is self-sustaining, because it eliminates an important "feedback loop." The staffs are hesitant to "communicate" their concerns if they do not perceive the manager as receptive.

In short, you may be fostering poor communication and never know it. You may see the symptoms, but unless you are looking carefully, you may not identify your own involvement in the problem. What can you do about it? Effective organizational communication, regardless of form, requires the following:

1. All players must have the appropriate skills and understanding to communicate well. Communication is not a simple process, and many people simply do not have the required knowledge base. Literature, classes and workshops can help develop communication skills.

2. There should be a climate or culture that supports effective communication. More specifically, this climate involves trust, openness, reinforcement of good communication practices and shared responsibility for making communication effective.

3. Effective communication requires attention. It doesn't just happen but develops as a result of an intentional effort on the part of management and staff. Too often communication, whether it is good or bad, is taken for granted.

4. Realize that you play a critical role in fostering and nurturing a climate that is characterized by open communication.

5. Finally, you must bring communication to the forefront of organization attention. If you make the effort to improve communication, your staff will recognize that it is important. If you ignore it, so will your staff.

Some Specific Tips:

Actively solicit feedback about your own communication and communication within the organization. Ask staff questions like: When we talk, are you generally clear about what I am saying? Do you think we communicate well around here? What are your ideas about how we could communicate better?

Working with your staff, define how you should communicate in the organization. Develop consensus regarding: how disagreements should be handled; how horizontal communication should work (staff to staff); how vertical communication should work (manager to staff, staff to manager); what information should be available and when. Once consensus is reached, support the achievement of these goals through positive reinforcement and coaching. Look at the impact of the structure of your organization and how it impacts on communication. Indirect communication through different channels is notorious for causing problems. Look at increasing direct communication where the person with the message to send does it directly with the receiver. Learn about and use active listening techniques. This will set a tone and contribute to a positive communication climate.

Units of Service

Did you know that you can use the "Units of Service" field to optimize reimbursement at your MTF? For example, there are CPT codes that are timed or have an associated range. One example is physical or occupational therapy services. Many of the codes in the Physical Medicine section of the CPT are "timed" in 15-minute increments. However, therapists often provide services that are more than 15-minutes long. If the therapist provided 30-minutes of therapeutic exercises, the code would be billed twice. Coding of this would be accomplished through ADM, which has a unit of service field where a "2" would be placed. On the billing side, TPOCS will place this number on the UB-92 (FL 46) and CMS-1500 (Item 24G) Claim Forms. The "Units of Service" field could also be used when providing a supply multiple times.

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("Big Bang")

Members of the TMA UBO Program team visited a total of 12 MTFs across all three Services during the dates of October 1-4, 2002. The MTFs visited included: **Army** - Brooke Army Medical Center, Ft. Hood – Darnall Community Hospital, Ft. Irwin – Weed Army Community Hospital, Walter Reed Army Medical Center; **Navy** - National Naval Medical Center Bethesda, Naval Hospital Twentynine Palms, Naval Hospital Camp Pendleton, Naval Medical Center San Diego; **Air Force** - 61st Medical Squadron – Los Angeles AFB; 95th Medical Group – Edwards AFB, Malcolm Grow Medical Center – Andrews AFB, Wilford Hall Medical Center.

The purpose of these visits was to observe the transition to OIB and provide any support needed by the MTFs. Team members visited the UBO and clinical areas. Their areas of focus were on stakeholders (coders, billers, and providers) and their use of OIB systems (CHCS, ADM, and TPOCS).

Motivation is what gets you started. Habit is what keeps you going.
--Unknown

It was discovered that MTFs were at various levels of readiness for OIB; some MTFs have been preparing for OIB for the past year and others were just getting started. CHCS, ADM, and TPOCS systems were also up and running at various levels; some sites had their TPOCS Server installed while others were awaiting their arrival.

Future Itemized Billing Efforts

In the spring of 2003, a coding compliance checker/editor to help with coding errors will be linked to CHCS.

Also, DoD UBO is scheduled to provide additional functional training to MTFs as funding permits. Contact your Service UBO Manager if you would like to be placed on the list

Improvements of screen flows, access of information, etc. are currently being programmed.

You are what you think. You are what you go for. You are what you do!
--Bob Richards

PROJECT MANAGEMENT

Evaluate what can take you away from your priorities: Stress? Phones? Meetings?

Plan your projects with the most priority around times that you find less distracting.

Start the day with a 15-minute overview of what needs to be accomplished. Put all tasks in priority order, and then you'll have a "blueprint" for your day.

If you get distracted, it's easy to pick up where you left off.

GOT QUESTIONS? Get Answers

Frequently Asked Questions on

www.tricare.osd.mil

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